IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

December 22, 2010

Mr. Torrey Bollinger, Administrator
Preferred Community Homes - Vineyards
7091 West Emerald Street
Boise, ID 83704

RE: Preferred Community Homes - Vineyards, Provider #13G028

Dear Mr. Bollinger:

This is to advise you of the findings of the Medicaid/Licensure survey of Preferred Community Homes - Vineyards, which was conducted on December 17, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner**:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of

being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **January 3, 2011,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by January 3, 2011. If a request for informal dispute resolution is received after January 3, 2011, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

JAMES TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/srm
Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G028	A. BUILDING _____ B. WING _____	12/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - VINEYARDS	2226 WEST SONOMA DRIVE MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Jim Troutfetter, QMRP, Team Leader Trish O'Hara, RN Common abbreviations/symbols used in this report are: AQIDP - Assistant Qualified Intellectual Disability Professional Dexascan - Dual-emission X-ray absorptiometry (bone density test) IDT - Interdisciplinary Team LPN - Licensed Practical Nurse MR - Mental retardation PCLP - Person Centered Lifestyle Plan PT - Physical Therapy QMRP - Qualified Mental Retardation Professional RN - Registered Nurse ROM - Range of motion (exercises)	W 000	"Preparation and implementation of this plan of corrections does not constitute admission or agreement by Vineyards with the facts, findings, or other statements as alleged by the State agency dated December 17, 2010. Submission of this plan of correction is required by law and does not evidence the truth of any of the findings as stated by the survey agency. Vineyards specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action." RECEIVED JAN - 3 2011 FACILITY STANDARDS	
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined staff were not able to demonstrate the skills and techniques necessary to implement an individual's physical therapy program for 1 of 3 Individuals (Individual #3) whose physical therapy programs were reviewed. This resulted in an individual not receiving	W 194	**W 194 483.430(e)(4) STAFF TRAINING PROGRAM** All staff will be re-trained on all residents' OT and PT programs and their instructions. Monthly spot check observations will be conducted by the RSC to ensure that programs are being ran correctly and instructions are being followed. This will be documented on an observation tracking sheet. The AQIDP will do monthly spot checks on this tracking sheet to ensure the observations are being done. The	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 12/30/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G028	A. BUILDING _____ B. WING _____	12/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - VINEYARDS	2226 WEST SONOMA DRIVE MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 194	Continued From page 1 services as recommended. The findings include: Individual #3's PCLP, dated 1/28/10, documented a 40 year old male diagnosed with profound MR. He was noted to use a walker for mobility and had a brace attached to his right boot. His physical therapy program contained directions for stretching the inner thigh and groin. The directions stated "Place heels together and pull feet towards groin until stretch is felt in groin and inner thigh. Hold 60 seconds." However, during an observation on 12/13/10 from 1:53 - 2:31 p.m., staff was noted to hold the stretch for 10 seconds. When asked during an interview on 12/17/10 from 8:55 - 9:30 a.m., the AQIDP stated the stretch should have been held for 60 seconds. The facility failed to ensure Individual #3's physical therapy program was implemented as written.	W 194	AQIDP will initial the sheet to signify that the observation was completed. Persons responsible: Direct Care Staff, RSC, and AQIDP Completion date: February 1st, 2011	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interviews it was determined the facility failed to ensure individuals were provided with general and preventative medical care for 2 of 3 individuals (Individuals #1 and #2) whose medical records were reviewed. This resulted in individuals not	W 322	**W 322 483.460(a)(3) PHYSICIAN SERVICES** All resident medical charts will be reviewed to ensure that all doctors' orders are being followed and that all individuals are being provided with adequate general and preventative medical care. The nursing department will hold weekly meetings to discuss current doctors' orders and nursing concerns throughout the company. The RN will do quarterly audits to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G028	A. BUILDING _____ B. WING _____	12/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - VINEYARDS	2226 WEST SONOMA DRIVE MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 2 receiving PT services and radiologic services. The findings include: 1. Individual #1's PCLP, dated 5/12/10, documented a 62 year old female with diagnoses including severe MR and seizure disorder. She experienced a fractured right clavicle on or about 8/02/10. Her medical record included a doctor's order, dated 9/1/10 that read,"Gentle shoulder range of motion as tolerated." Another doctor's order, dated 9/30/10 read,"full ROM of Rt. [Right] shoulder as tolerated." Individual #1's medical record contained a Physical Therapy evaluation dated 10/30/10. This evaluation contained instructions to "begin shoulder ROM program..." In an interview, on 12/17/10 at 9:30 a.m., the AQIDP stated that all physical therapy, including routine exercise described in Individual #1's PCLP, had been discontinued for Individual #1 at the time of the fracture and had not been resumed until after the physical therapy evaluation. Individual #1 did not receive gentle ROM or full ROM exercise as ordered by the physician. 2. Individual #2's PCLP, dated 7/23/10, documented a 33 year old male with diagnoses of moderate MR, Cerebral Palsy, spastic quadriplegia, and history of seizure disorder. Individual #2's medical record documented Individual #2 had a Dexascan performed on 11/30/05. Results of the scan showed Individual #2 had severe osteoporosis (loss of bone density.) He was currently receiving medication	W 322	**the all doctors' orders are being followed and that all individuals are being provided with adequate general and preventative medical care.** **Person responsible: RN, LPN** **Completion date: February 1st, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G028	A. BUILDING _____ B. WING _____	12/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - VINEYARDS	2226 WEST SONOMA DRIVE MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 3 for the condition. The American Association of Clinical Endocrinologist's recommendation in the Journal of Family Practice, dated January 2005, indicated a follow up Dexascan yearly, after the initiation of treatment for osteoporosis, until bone mass has stabilized. Then follow up measurements were recommended every two years. Further, the National Osteoporosis Foundation recommended a Dexascan 1-2 years following initiation of therapy, and an article, published in Nutrition and Metabolism, in 2006, stated bone mineral density with Dexascan should be monitored at regular intervals of 12 - 18 months to monitor response to treatment. In an interview on 12/17/10 at 9:00 AM, the facility nurse stated the IDT discussed obtaining a Dexascan for Individual #2 but did not do so because his insurance would not pay for the test. The facility failed to ensure Individual #2 received appropriate bone density monitoring.	W 322		
W 420	483.470(b)(4)(iv) CLIENT BEDROOMS The facility must provide each client with functional furniture, appropriate to the clients needs. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure functional furniture was provided for 1 of 6 individuals (Individual #1) residing at the facility. This resulted in the individual's independence being impeded by the her inability to exit a reclining	W 420	**W 420 483.470(b)(4)(iv) CLIENT BEDROOMS** All furniture in the home will be assessed by the Physical Therapist to ensure that it is safe for all residents to get in and out of independently. If there is furniture that is deemed unsafe, it will be replaced. Anytime that new furniture is replaced or bought for the home, the RSC will ensure that it is safe for all residents to get in and out of independently.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G028	A. BUILDING _____ B. WING _____	12/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - VINEYARDS	2226 WEST SONOMA DRIVE MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 420	Continued From page 4 chair. The findings include: Individual #1's PCLP, dated 5/12/10, documented a 62 year old female with diagnoses including severe MR, and seizure disorder. She was non-verbal, wore a protective helmet, and wore a gait belt for ambulation assistance due to her unstable gait. During observations on 12/13/10 at 4:35 p.m., on 12/13/10 at 6:40 p.m., and on 12/14/10 at 10:00 AM, Individual #1 was placed, by staff, in a reclining chair in the living room of the facility. The staff then used a handle on the side of the chair to elevate the foot rest of the chair. Individual #1 was not observed to exit the chair independently. Staff was observed three times putting the foot rest of the chair down and assisting Individual #1 to exit the chair. In an interview on 12/16/10 from 10:00 - 10:30 a.m., three direct care staff confirmed Individual #1 was not able to lower the foot rest of the chair independently. The three direct care staff further stated Individual #1 sometimes exited the chair by placing her legs over the side of the foot rest and all confirmed this was an unsafe activity for Individual #1. In an interview on 12/16/10 at 9:45 a.m., the home manager confirmed Individual #1 was not able to independently lower the foot rest on the chair in order to safely exit the chair. In an interview on 12/17/10 at 9:30 a.m. the AQIDP confirmed Individual #1 was not able to lower the foot rest on the chair independently, but stated staff was available to assist her to exit the chair.	W 420	**Person responsible: RSC, Physical Therapist** **Completion date: February 1st, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G028	A. BUILDING _____ B. WING _____	12/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - VINEYARDS	2226 WEST SONOMA DRIVE MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 420	Continued From page 5 The facility failed to ensure Individual #1 was provided with functional furniture necessary to maximize her independence.	W 420		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G028	A. BUILDING _____ B. WING _____	12/17/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - VINEYARI	2226 WEST SONOMA DRIVE MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM430	16.03.11.120.11(a) Amount of Equipment and Supplies The amount of equipment and supplies of various kinds will vary according to the size of the facility and the type of residents. This Rule is not met as evidenced by: Refer to W420.	MM430	**MM430 16.03.11.120.11(a) AMOUNT OF EQUIPMENT AND SUPPLIES** **Please refer to the plan of correction for W420**	
MM620	16.03.11.230.05(b) Upgrading of Competencies The upgrading of competencies to improve skills based on resident needs and corresponding staff expertise; and This Rule is not met as evidenced by: Refer to W194.	MM620	**MM620 16.03.11.230.05(b) UPGRADING OF COMPETENCIES** **Please refer to the plan of correction for W194**	
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735	**MM735 16.03.11.270.02 HEALTH SERVICES** **Please refer to the plan of correction for W322**	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 12/30/10